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Patient Label

OSHA RESPIRATORY FORM

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (MANDATORY)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination

To the employee:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it

PART A. SECTION 1. (MANDATORY) The following information must be provided by every employee who has been selected to use any type of respirator (PLEASE PRINT).

Today's Date: _____/_____/_____

Your name: _____

Employee #: _____

Your job title: _____

Sex: ☐ Male ☐ Female

Manager name: _____

Department: _____ Etx. _____

Your Age: _____

Telephone #: (____) _____ - _____

Your Weight: _____ kg

Best time to reach you at above number:

Your Height: _____ ft. _____ in.

_____ ☐ AM ☐ PM

Has your employer informed you on how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No

Check the type of respirator you will use: (*you may check more than one category*)

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied air, self-contained breathing apparatus: (please list) _____

Have you previously worn a respirator? ☐ Yes ☐ No

If yes, what type(s)? _____



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PART A. SECTION 2. (MANDATORY) Questions 1-9 below must be answered by every employee who has been selected to use any type of respirator.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ Yes ☐ No

Please indicate "YES" or "NO" and explain all "YES" answers in the right hand column.

2. Do you have now or ever had any of the below conditions?

YES NO

EXPLAIN "YES" ANSWERS:

Seizures

☐☐

Diabetes (sugar disease)

☐☐

Allergic reactions that interfere with your breathing

☐☐

Claustrophobia (fear of closed-in places)

☐☐

Trouble smelling odors (except with a cold)

☐☐

3. Do you have now or ever had any of the below pulmonary or lung problems?

YES NO

EXPLAIN "YES" ANSWERS:

Asbestosis

☐☐

Asthma

☐☐

Chronic Bronchitis

☐☐

Emphysema/COPD

☐☐

Pneumonia

☐☐

Tuberculosis

☐☐

Silicosis

☐☐

Pneumothorax (collapsed lung)

☐☐

Lung cancer

☐☐

Broken ribs

☐☐

Any chest injuries or surgeries

☐☐

Any other lung problems you have been told about

☐☐

4. Do you have now or ever had any of the below pulmonary or lung illness?

YES NO

EXPLAIN "YES" ANSWERS:

Shortness of breath

☐☐

Shortness of breath when walking fast on ground or walking up a slight hill or incline

☐☐

Shortness of breath when walking with other people at an ordinary pace on level ground

☐☐

Have to stop for breath when walking at your own pace on level ground

☐☐



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(Continued from page 2.)

4. Do you have now or ever had any of the below pulmonary or lung illness?

YES

NO

EXPLAIN "YES" ANSWERS:

Shortness of breath when washing or dressing

☐☐

Shortness of breath that interferes with your job

☐☐

Coughing that produces phlegm (thick sputum)

☐☐

Coughing that wakes you early in the morning

☐☐

Coughing that occurs mostly when you are lying down

☐☐

Coughing up blood in the last month

☐☐

Wheezing

☐☐

Wheezing that interferes with your job

☐☐

Chest pain when you breathe deeply

☐☐

Any other symptoms that you think may be related to lung problems

☐☐

5. Have you ever had any of the following cardiovascular or heart problems?

YES

NO

EXPLAIN "YES" ANSWERS:

Heart attack

☐☐

Stroke

☐☐

Angina

☐☐

Heart failure

☐☐

Swelling in your legs or feet (not caused by walking)

☐☐

Heart arrhythmia (heart beating irregularly)

☐☐

High blood pressure

☐☐

Any other heart problems you have been told about

☐☐

6. Have you ever had any of the following cardiovascular or heart symptoms?

YES

NO

EXPLAIN "YES" ANSWERS:

Frequent pain or tightness in your chest

☐☐

Pain or tightness in your chest during physical activity

☐☐

Pain or tightness in your chest that interferes with your job

☐☐

In the past two years, have you noticed your heart skipping or missing a beat

☐☐

Heartburn or indigestion that is not related to eating

☐☐

Any other symptoms that you think may be related to heart or circulation problems

☐☐



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7. Do you currently take medication for any of the following problems?

	YES	NO	EXPLAIN "YES" ANSWERS:
Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____

8. If you have used a respirator, have you ever had any of the following problems?

YES NO EXPLAIN "YES" ANSWERS:

(If you have never used a respirator, check the following space and go to question 9.) ☐ never

Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other problems that interfere with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>	_____

9. Would you like to speak with the healthcare professional who will review this questionnaire about your answers to this questionnaire? ☐ Yes ☐ No

ONLY COMPLETE SECTIONS BELOW FOR HALF FACE/FULL FACE/ SCBA RESPIRATORS

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

PART A: SECTION 3.

10. Have you ever lost vision in either eye (temporarily or permanently)? ☐ Yes ☐ No

11. Do you currently have any of these vision problems?

YES NO EXPLAIN "YES" ANSWERS:

Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color blind	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>	_____



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12. Have you ever had any injury to your ears, including a broken ear drum? ☐ Yes ☐ No

13. Do you currently have any of these hearing problems?

YES

NO

EXPLAIN "YES" ANSWERS:

Difficulty hearing

☐☐

Wearing a hearing aid

☐☐

Any other hearing or ear problem

☐☐

14. Have you ever had a back injury? ☐ Yes ☐ No

15. Do you currently have any of the following musculoskeletal problems?

YES

NO

EXPLAIN "YES" ANSWERS:

Weakness in any of your arms, hands, legs, or feet

☐☐

Back pain

☐☐

Difficulty fully moving your arms or legs

☐☐

Pain or stiffness when you lean forward or backwards at the waist

☐☐

Difficulty moving your head up or down

☐☐

Difficulty moving your head side to side

☐☐

Difficulty bending at your knees

☐☐

Difficulty squatting to the ground

☐☐

Climbing a flight of stairs or a ladder carrying more than 25 lbs.

☐☐

Any other muscle or skeletal problem that interferes with using a respirator

☐☐

PART B: SECTION 1.: Complete this section (questions 1-19) if this the first OSHA Respiratory Questionnaire you have filled out for your employer. Otherwise fill this section out at the discretion of the health care provider.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? ☐ Yes ☐ No

If "YES", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions? ☐ Yes ☐ No



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2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (such as gases, fumes, or dust) OR have you come into skin contact with hazardous chemicals?

☐ Yes ☐ No

If "YES", name the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions listed below?

	YES	NO	EXPLAIN "YES" ANSWERS:
Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____
Silica (e.g., in sandblasting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tungsten / cobalt (e.g., grinding or welding material)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Beryllium	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aluminum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coal (e.g, mining)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iron	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dusty environments	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other hazardous exposures	<input type="checkbox"/>	<input type="checkbox"/>	_____

If "YES", describe these exposures: _____

4. List any second jobs or side businesses you may have: _____

5. List your previous occupations: _____



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6. List your current and previous hobbies: _____

7. Have you been in the military services? ☐ Yes ☐ No

If "YES", were you exposed to biological or chemical agents (either in training or combat?

☐ Yes ☐ No

8. Have you ever worked on the HAZMAT team? ☐ Yes ☐ No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizure mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medication)? ☐ Yes ☐ No

If "YES", please name them: _____

10. Will you be using any of the following items with your respirator?

YES NO EXPLAIN "YES" ANSWERS:

HEPA filters

☐

☐

Canisters (for example, gas masks)

☐

☐

Cartridges

☐

☐

11. How often are you expected to use the respirator?

YES NO EXPLAIN "YES" ANSWERS:

Escape-only (no rescue)

☐

☐

Emergency rescue only

☐

☐

Less than 5 hours per week

☐

☐

Less than 2 hours per day

☐

☐

2 to 4 hours per day

☐

☐

Over 4 hours per day

☐

☐

12. During the period you are using the respirator(s), is your work effort:

a. "light" (less than 200 kcal per hour)? ☐ Yes ☐ No

Examples of "light work effort" are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3lbs.) or controlling machines.

If "YES", how long does this period last during the average shift? _____ hours _____ minutes



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b. "moderate" (200 to 350 kcal per hour)? ☐ Yes ☐ No

Examples of "moderate work effort" are sitting while nailing or filing, driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

If "YES", how long does this period last during the average shift? _____ hours _____ minutes

c. "heavy" (about 350 kcal per hour)? ☐ Yes ☐ No

Examples of "heavy work load" are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up a 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)

If "YES", how long does this period last during the average shift? _____ hours _____ minutes

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator? ☐ Yes ☐ No

If "YES", please describe the protective clothing: _____

14. Will you be working under hot conditions (temperature exceeding 77°F)? ☐ Yes ☐ No

15. Will you working under humid conditions? ☐ Yes ☐ No

16. Describe the work you will be doing while using your respirator(s): _____

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases): _____

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):

Name of 1st toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____



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Name of 2nd toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of 3rd toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Please provide the name of any other toxic substances that you will exposed to while wearing your respirator(s): _____

19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security): _____

I shall report to management any changes in my health condition that are related to my ability to use a respirator.

I understand, hereby certify that the answers to the above questions are true to the best of my knowledge.

Employee Signature

Date

Time

Occupational Health

Reviewed Date

Reviewed Time

Comments: _____

Licensed Practitioner Signature

Date

Time